RULES
OF
TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION

CHAPTER 0800-2-19
IN-PATIENT HOSPITAL FEE SCHEDULE

TABLE OF CONTENTS

0800-2-19-.01 GENERAL RULES.

(1) These In-patient Hospital Fee Schedule Rules shall become effective May 1, 2006 and are applicable to all in-patient services as defined herein. These include medical, surgical, rehabilitation, and/or psychiatric services rendered in a hospital to injured or ill workers claiming medical benefits pursuant to the Tennessee Workers' Compensation Act. Maximum fees for outpatient hospital services are not addressed in these In-patient Hospital Fee Schedule Rules, but are addressed in Rule 0800-2-18-.07 of the Medical Fee Schedule Rules, Chapter 0800-2-18-.01 et seq. These In-patient Hospital Fee Schedule Rules are established pursuant to Tenn. Code Ann. § 50-6-204 (Repl. 2005). They must be used in conjunction with the Medical Cost Containment Program Rules, Chapter 0800-2-17-.01 et seq., and the Medical Fee Schedule Rules, Chapter 0800-2-18-.01 et seq., as the definitions and provisions set forth in those rules are incorporated as if set forth fully herein.

(2) General Information

(a) Reimbursements shall be determined for services rendered in accordance with these Fee Schedule Rules and shall be considered to be inclusive unless otherwise expressly noted in these Rules.

(b) The most current Medicare procedures and guidelines are hereby adopted and incorporated as part of these Rules as if fully set out herein and shall be effective upon adoption and implementation by the CMS. All such Medicare procedures and guidelines are applicable unless these Rules set forth a different procedure or guideline. Whenever there is no specific maximum fee or methodology for reimbursement set forth in these Rules for a service, diagnostic procedure, equipment, etc., then the maximum amount of reimbursement shall be 100% of the most current and effective CMS' Medicare allowable amount and the most current effective Medicare guidelines and procedures shall be followed in arriving at the correct amount. Whenever there is no applicable Medicare code, the service, equipment, diagnostic procedure, etc. shall be reimbursed up to a maximum of the usual and customary amount, as defined in Rule 0800-2-17-.03(80) of the Medical Cost Containment Rules.

(c) Reimbursement for a compensable workers' compensation claim shall be the lesser of the hospital's usual and customary charges or the maximum amount allowed under this In-patient Hospital Fee Schedule.

(d) In-patient hospitals shall be grouped into the following separate peer groupings:

1. Peer Group 1 Hospitals

2. Peer Group 2 Rehabilitation Hospitals

(Rule 0800-2-19-.01, continued)

3. Peer Group 3 Psychiatric Hospitals

(e) For each inpatient claim submitted, the provider shall assign a Medicare Diagnosis Related Group ("DRG") code which appropriately reflects the patient's primary cause of hospitalization.

(f) This In-patient Hospital Fee Schedule shall become effective May 1, 2006, shall be reviewed annually, and may be updated annually.

(g) Ongoing analysis will be conducted as to the projected savings of this schedule, as well as any impact on patient services.

(h) Pre-admission utilization review is required for inpatient services and emergency admissions require utilization review begin within one (1) business day of the admission.

Authority: *T.C.A. §§ 50-6-125, 50-6-128, 50-6-204 and 50-6-205 (Repl. 2005).* ***Administrative History:*** *Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.*

0800-2-19-.02 DEFINITIONS.

(1) "Administrator" means the chief administrative officer of the Division of Workers' Compensation of the Tennessee Department of Labor and Workforce Development.

(2) "Allowed Charges" or "Allowable Charges" shall mean charges reviewed and approved under an appropriate audit and utilization review by the carrier as prescribed in the Division's Rules, or as determined by the Commissioner or the Commissioner's designee after consultation with the Division's Medical Director.

(3) "Commissioner" means the Commissioner of the Tennessee Department of Labor and Workforce Development.

(4) "Division" means the Division of Workers' Compensation of the Tennessee Department of Labor and Workforce Development.

(5) DRG – Medicare classifications of diagnosis in which patients demonstrate similar resource consumption and length of stay patterns.

(6) In-patient Services - Services rendered to a person who is formally admitted to a hospital and whose length of stay exceeds 23 hours.

(7) Institutional Services - All non-physician services rendered within the institution by an agent of the institution.

(8) Length of Stay ("LOS") - Number of days of admission where patient appears on midnight census. Last day of stay shall count as an admission day if it is medically necessary for the patient to remain in the hospital beyond 12:00 noon.

(9) Medical Admission - Any hospital admission where the primary services rendered are not surgical, psychiatric, or rehabilitative in nature.

(10) Stop-Loss Payment ("SLP") - An independent method of payment for an unusually costly or lengthy stay.

(Rule 0800-2-19-.02, continued)

(11) Stop-Loss Reimbursement Factor ("SLRF") - A factor established by the Division to be used as a multiplier to establish a reimbursement amount when total hospital charges have exceeded specific stop-loss thresholds.

(12) Stop-Loss Threshold ("SLT") - Threshold of total charges established by the Division, beyond which reimbursement is calculated by multiplying the applicable Stop-Loss Reimbursement Factor times the total charges identifying that particular threshold.

(13) Surgical Admission - Any hospital admission where there is an operating room charge, the patient has a surgical procedure or ICD-9 code, or the patient has a surgical DRG as defined by the CMS.

(14) Transfers Between Facilities - To move or remove a patient from one facility to another for a purpose related to obtaining or continuing medical care. May or may not involve a change in the admittance status of the patient, i.e. patient transported from one facility to another to obtain specific care, diagnostic testing, or other medical services not available in facility in which patient has been admitted. Includes costs related to transportation of patient to obtain medical care.

(15) "Trauma Admission" - means any hospital admission in which the patient has a diagnosis code of 800 to 959.99.

(16) "Usual and customary charge" means eighty-five percent (85%) of a specific provider's average charges to all payers for the same procedure.

(17) "Utilization Review" means evaluation of the necessity, appropriateness, efficiency and quality of medical care services provided to an injured or disabled employee based on medically accepted standards and an objective evaluation of the medical care services provided; provided, that "utilization review" does not include the establishment of approved payment levels or a review of medical charges or fees.

(18) Workers' Compensation Standard Per Diem Amount ("SPDA") - A standardized per diem amount established for the reimbursement of hospitals for services rendered.

Authority: *T.C.A. §§ 50-6-125, 50-6-128, 50-6-204 and 50-6-205 (Repl. 2005).* ***Administrative History:*** *Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.*

0800-2-19-.03 SPECIAL GROUND RULES – INPATIENT HOSPITAL SERVICES.

(1) This section defines the reimbursement procedures and calculations for inpatient health care services by all hospitals. Hospital reimbursement is divided into two (2) groups based on type of admission (surgical or non-surgical (medical)) and length of stay (less than eight (8) days/over seven (7) days). Rehabilitation and Psychiatric hospitals are grouped separately.

(2) General Information

(a) For each inpatient claim submitted, the provider shall assign a Diagnosis Related Group (DRG) code which appropriately reflects the patient's primary cause for hospitalization to determine average length of stay and for tracking purposes. Hospitals within each peer group are subject to a maximum amount per inpatient day.

(Rule 0800-2-19-.03, continued)

(b) The maximum per diem rates to be used in calculating the reimbursement rate is as follows:

1.	Peer Group 1	$1,800.00 Surgical adm. for the first seven (7) days; 1,500.00 per day thereafter (surgical adm.) Includes Intensive Care (ICU) & Critical Care (CCU) $1,500.00 Medical adm. for first seven (7) days; 1,250.00 per day thereafter (medical adm.)
2.	Peer Group 2 (Rehabilitation)	$1,000.00 For the first seven (7) days; 800.00 per day thereafter
3.	Peer Group 3	$ 700.00 Psychiatric Hospitals (applicable to chemical dependency as well.)

(c) All trauma care at any licensed Level 1 Trauma Center only shall be reimbursed at a maximum rate of $3,000.00 per day for each day of patient stay.

(d) Surgical implants shall be reimbursed separately and in addition to the per diem hospital charges.

1. Reimbursement for trauma inpatient hospital services shall be limited to the lesser of the maximum allowable as calculated by the appropriate per diem rate, or the hospital's billed charges minus any non-covered charges.

2. Non-covered charges are: convenience items, charges for services not related to the work injury/illness services that were not certified by the payer or their representative as medically necessary.

3. Additional reimbursement may be made in addition to the per diem for implantables (i.e. rods, pins, plates and joint replacements, etc.). Maximum reimbursement for implantables for which charges are $100.00 or less per item shall be limited to eighty-five percent (85%) of billed charges. Maximum reimbursement for implantables for which charges are over $100.00 is limited to a maximum of the hospital's cost plus fifteen percent (15%) of the invoice amount, up to a maximum of invoice plus $1,000.00. This is applicable per item, and is not cumulative. Implantables shall be billed using the appropriate HCPCS codes, when available. Billing for implantables which have an invoice amount over $100.00 shall be accompanied by an invoice if requested by the payer.

4. The following items are not included in the per diem reimbursement to the facility and may be reimbursed separately. All of these items must be listed with the applicable CPT/HCPCS.

(i) Durable Medical Equipment

(ii) Orthotics and Prosthetics

(iii) Implantables

(iv) Ambulance Services

(v) Take home medications and supplies

(vi) Radiology Services

(vii) Pathology Services

(e) The items listed in subsection (d)(4) shall be reimbursed according to the Medical Cost Containment Program Rules (Chapter 0800-2-17) and Medical Fee Schedule Rules (Chapter 0800-2-18) payment limits. Items not listed in the Rules shall be reimbursed at the usual and customary rate as defined in Rule 0800-2-17-.03(80), unless otherwise indicated herein.

(f) Per diem rates are all inclusive (with the exception of those items listed in subsection (d)(4) above).

(g) The In-patient Hospital Fee Schedule allows for independent reimbursement on a case-by-case basis if the particular care exceeds the Stop-Loss Threshold.

(3) Reimbursement Calculations

(a) Explanation

1. Each admission is assigned an appropriate DRG.

2. The applicable Standard Per Diem Amount ("SPDA") is multiplied by the length of stay ("LOS") for that admission.

3. The Workers' Compensation Reimbursement Amount ("WCRA") is the total amount of reimbursement to be made for that particular admission.

(b) Formula: LOS X SPDA = WCRA

(c) Example: DRG 222: Knee Procedures W/O CC

Hospital Peer Group: 1-Surgical admission:
Maximum rate per day: $1,800 first seven (7) days/$1,500 per day each day thereafter
Number billed days: 9
Billed charges: $15,600

Maximum Allowable Payment: $15,600

(4) Stop-Loss Method

(a) Stop-loss is an independent reimbursement factor established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.

(b) Explanation

1. To be eligible for stop loss payment, the total Allowed Charges for a hospital admission must exceed the hospital maximum payment, as determined by the hospital maximum payment rate per day, by at least $15,000. Amounts for items set forth in rule 0800-2-19-.03(d)(4.), such as implantables, radiology, pathology services, DME, etc., shall not be included in determining the total Allowed Charges for stop-loss calculations.

(Rule 0800-2-19-.03, continued)

2. This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.

3. Once the allowed charges reach the stop-loss threshold, reimbursement for all additional charges shall be made based on a stop-loss payment factor of 80%.

4. The additional charges are multiplied by the Stop-Loss Reimbursement Factor (SLRF) and added to the maximum allowable payment.

(c) Formula: (Additional Charges x SLRF) + Maximum Allowable Payment = WCRA

(d) Example: DRG 222: Knee Procedures W/O CC

Hospital Peer Group: 1 – Surgical admission
Maximum rate per day: $1,800 for first 7 days; 1,500 for 2 additional days
Number Billed Days: 9
Total Billed Charges: $37,600.00

Maximum allowable payment for
Normal DRG stay.....$15,600.00

Versus: billed charges $37,600.00

Amount Payable Before Stop-Loss,
Lower of Charge vs. Maximum Allowable..... $15,600.00

Total difference, charges over and above maximum payments $22,000.00

Difference over and above $15,000 Stop-loss is..... $7,000.00
Payable under Stop-loss (80% of 7,000.00)..... $5,600.00

Total payment
due hospital: .....$21,200.00 ..... (15,600+5,600)

(5) Billing for In-patient Admissions

(a) All bills for in-patient institutional services should be submitted on the standard UB-92 form or any revision to that form approved for use by the CMS.

Authority: *T.C.A. §§ 50-6-125, 50-6-128, 50-6-204 and 50-6-205 (Repl. 2005).* ***Administrative History:*** *Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.*

0800-2-19-.04 PRE-ADMISSION UTILIZATION REVIEW.

(1) Procedures For Requesting Pre-admission Utilization Review

(a) The insurance carrier shall be liable for the reasonable and necessary medical costs relating to the health care treatments and services listed in subparagraph (g) of this Rule required to treat a compensable injury, when any of the following situations occur:

1. the treating doctor, his/her designated representative, or injured employee has received approval after utilization review from the carrier prior to the health care treatments or services;

2. the carrier has failed to communicate approval or denial of the healthcare treatment or services within seven (7) business days of a provider's request for utilization review and approval; or

3. when ordered by the Division.

(b) The insurance carrier shall designate an accessible direct telephone number, and may also designate a facsimile number for use by the provider or the provider's designated representative or the injured employee to request utilization review and approval during normal business hours. The direct number shall be answered or the facsimile responded to, by the carrier's agent who is delegated to approve or deny requests, within the time limits established in subsection (d) of this paragraph.

(c) Prior to the date of proposed treatment or services, the provider or the provider's designated representative, shall notify the insurance carrier's delegated agent, by telephone or transmission of a facsimile, of the recommended treatment or service listed in subparagraph (g) of this Rule. Notification shall include the medical information to substantiate the need for the treatment or service recommended. If requested to do so by the carrier, the treating doctor shall also notify the insurance carrier of the location and estimated date of the recommended treatment or service, and the name of the health care provider performing the treatment or service, if other than the provider. Designated representative includes, but is not limited to, office staff, hospitals, etc.

(d) Within seven (7) business days of the provider's request for utilization review and approval, the insurance carrier's delegated agent shall notify the provider or the provider's designated representative, by telephone or transmission of a facsimile, of the insurance carrier's decision to grant or deny. Failure of the carrier to communicate its approval or denial within seven (7) business days of a provider's request shall automatically be deemed an approval of the request. When the insurance carrier approves, the insurance carrier shall send written approval, or if denying, shall send documentation identifying the reasons for denial. Notification shall be sent to the injured employee, the injured employee's representative if known, and the provider or the provider's designated representative, within 24 hours after notification of denial or approval.

(e) The insurance carrier shall maintain accurate records to reflect information regarding the utilization review request and approval/denial process.

(f) If a dispute arises over denial by the insurance carrier, the doctor or the injured employee may file a Request for Assistance with a Benefit Review Specialist.

(g) The health care treatments and services requiring pre-admission utilization review are: all non-emergency hospitalizations, cases in which the cumulative medical costs of the case have reached $5000.00 or more, and non-emergency transfers between facilities.

Authority: *T.C.A. §§ 50-6-125, 50-6-128, 50-6-204 and 50-6-205 (Repl. 2005).* ***Administrative History:*** *Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.*

0800-2-19-.05 OTHER SERVICES.

(1) Pharmacy Services

(a) Pharmaceutical services rendered as part of in-patient care are considered inclusive within the In-patient Fee Schedule and shall not be reimbursed separately.

(Rule 0800-2-19-.05, continued)

(b) All retail pharmaceutical services rendered shall be reimbursed in accordance with the Pharmacy Schedule Guidelines, Rule 0800-2-18-.12.

(2) Professional Services

(a) All non-institutional professional services will be reimbursed in accordance with the Division's Medical Cost Containment Program Rules and Medical Fee Schedule Rules which must be used in conjunction with these Rules.

Authority: *T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204 and 50-6-205 (Repl. 2005).* ***Administrative History:*** *Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.*

0800-2-19-.06 PENALTIES FOR VIOLATIONS OF FEE SCHEDULES.

(1) Providers shall not accept and employers or carriers shall not pay any amount for health care services provided for the treatment of a covered injury or illness or for any other services encompassed within the Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, when that amount exceeds the maximum allowable payment established by these Rules. Any provider accepting and any employer or carrier paying an amount in excess of the Division's Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules shall be in violation of these Rules and may, at the Commissioner's discretion, be subject to civil penalties of ten thousand dollars ($10,000.00) per violation for each violation, which may be assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, whenever a pattern or practice of such activity is found. Any provider reimbursed or carrier paying an amount which is in excess of these Rules shall have a period of ninety (90) calendar days from the time of receipt/payment of such excessive payment in which to refund/recover the overpayment amount. Overpayments refunded/recovered within this time period shall not constitute a violation under these Rules. At the discretion of the Commissioner, the Commissioner's Designee, or an agency member appointed by the Commissioner, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Act. Any other violation of the Medical Cost Containment Program Rules, Medical Fee Schedule Rules, or the In-patient Hospital Fee Schedule Rules shall subject the alleged violator(s) to a civil penalty of not less than one hundred dollars ($100.00) nor more than ten thousand dollars ($10,000.00) per violation, at the discretion of the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner.

(2) Any provider reimbursed or carrier paying an amount which is in excess of these Rules shall have a period of ninety (90) calendar days from the time of receipt/payment of such excessive payment in which to refund/recover the overpayment amount. Overpayments refunded/recovered within this time period shall not constitute a violation under these Rules.

(3) A provider, employer or carrier found to be in violation of these Rules, whether a civil penalty is assessed or not, may request a contested case hearing by requesting such hearing in writing within fifteen (15) calendar days of issuance of a Notice of Violation and, if applicable, the notice of assessment of civil penalties. All rights, duties, obligations, and procedures applicable under the Uniform Administrative Procedures Act, Tenn. Code Ann. § 4-5-101 et seq., are applicable under these Rules, including, but not limited to, the right to judicial review of any final departmental decision.

(4) The request for a hearing shall be made to the Division in writing by an employer, carrier or provider which has been notified of its violation of these Rules, and if applicable, assessed a civil penalty.

(Rule 0800-2-19-.06, continued)

(5) Any request for a hearing shall be filed with the Division within fifteen (15) calendar days of the date of issuance of the Notice of Violation and, if applicable, of civil penalty. Failure to file a request for a hearing within fifteen (15) calendar days of the date of issuance of a Notice of Violation shall result in the decision of the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner becoming a final order and not subject to further review.

(6) The Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner shall have the authority to hear the matter as a contested case and determine if any civil penalty assessed should have been assessed. All procedural aspects set forth in the Division's Penalty Program Rules, Chapter 0800-2-13, shall apply and be followed in any such contested case hearing.

(7) Upon receipt of a timely filed request for a hearing, the Commissioner shall issue a Notice of Hearing to all interested parties.

Authority: *T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).* ***Administrative History:*** *Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006.*